LAI PING

v.

DR LIM TYE LING & ORS

HIGH COURT MALAYA, KUALA LUMPUR
SM KOMATHY SUPPIAH JC
[CIVIL SUIT NO: S6-22-252-2008]
5 FEBRUARY 2014

TORT: *Negligence - Medical negligence - Blindness due to endogenous endophthalmitis - Failure to give intravitreal injections - Plaintiff's poor health condition - Whether doctor's management of plaintiff was not in accordance with accepted treatment of endogenous endophthalmitis - Whether doctor negligent - Whether defence of novus actus interveniens applied*

On 15 July 2006, the plaintiff sought medical attention at Pantai Cheras Medical Centre. The plaintiff was admitted into the ward under the care of Dr Lim Tye Ling, a consultant physician ('first defendant'). On 16 July 2006, the plaintiff complained to the first defendant of some blurring of vision. The first defendant then contacted one Dr Ching Wing Seng ('the second defendant'), and requested that he saw the plaintiff for further management of her eye complaint. Following the second defendant's review of the plaintiff's eye, he planned to give intravitreal injections of Amikacin and Vancomycin in the operation theatre as soon as possible depending on the general condition of the plaintiff. In view of the plaintiff's systemic condition, the intravitreal injections were postponed. On 19 July 2006, the second defendant found that the plaintiff's right upper lid swelling had increased and a drainage of abscess was planned under general anaesthesia together with the administration of the intravitreal injections if the plaintiff was fit. However, there was a serious dispute as to whether Intravitreal Vancomycin and Amikacin injections were given by the second defendant that day. On 24 July 2006, the plaintiff discharged herself at her own risk (AOR) from the Hospital and did not return for follow up treatment. The plaintiff then sought treatment at Tung Shin Hospital and was under the care of one Dr Rita Yong Choy Lan, a consultant opthalmologist ('PW4'). PW4 referred the plaintiff to Dr Seshan Lim, a consultant eye surgeon ('PW5') for further treatment. The plaintiff then brought an action against the second defendant for medical negligence. The plaintiff alleged that due to the inadequate treatment received, she was now blind in both eyes. She held the second defendant responsible for her loss of vision due the latter's negligence and breach of duty of care. The plaintiff alleged that her eyes could have been saved if the second defendant had been more proactive and gave intravitreal antibiotic injections to the eyes and performed a procedure called vitrectomy as soon as she was diagnosed with endogenous endophthalmitis. On the

A contrary, the second defendant denied that he had been negligent. The second defendant contended that despite efforts to treat her eyes, the blindness was an unfortunate by product of endogenous endophthalmitis which had already set in by the time he first examined the plaintiff. Further, the second defendant contended that he could not administer
B intravitreal Vancomycin and Amikacin under local or general anaesthesia on the plaintiff because of the presence of pus, inflammation, swelling around the plaintiff's eyes and the plaintiff had low platelet count. The second defendant argued that he had to wait to ensure that the plaintiff's condition was stable before the injections could be given. Subsequently,
C the second defendant contended that he had administered the intravitreal eye injections during the examination of the plaintiff under anaesthesia procedure on 19 July 2006 although that was not mentioned in the operation record because he was called away before he could complete the record and sign off. The second defendant maintained that the failure to minute in the operation record that the intravitreal eye injections were
D given was not *ipso facto* conclusive proof that they were not given. In the alternate, the second defendant relied on the defence of *novus actus interveniens* based on the treatment given at Tung Shin Hospital. The plaintiff did not call any expert witness, but relied on the evidence of PW4 and PW5, whilst the second defendant relied on the evidence of
E his expert witness, Dr Pall Singh, a senior consultant ophthalmologist at Tun Hussein Onn National Eye Hospital to establish the common accepted practice in the treatment of endogenous endophthalmitis. There was a difference of opinion as to whether vitrectomy should be performed at an early stage of the treatment or should be performed
F after a week or two after the patient had been put on systemic intravenous antibiotics. The issues that arose for determination were, *inter alia,* (i) whether the second defendant administered the intravitreal injections during the procedure on 19 July 2006; (ii) whether the second defendant's management of the plaintiff was not in accordance with the
G accepted treatment of endogenous endophthalmitis; (iii) whether the second defendant's failure had caused blindness in both the plaintiff's eyes; and (iv) whether the alternative defence of *novus actus interveniens* applied in the circumstances of the case.

Held (dismissing plaintiff's claim with costs):

H

(1) There was unchallenged evidence that on 18 and 19 July 2006, the second defendant had arranged for the plaintiff to be given eye injections, but the injections scheduled for 18 July were cancelled, and that cancellation was recorded. However, there was no record
I of any cancellation of the injections scheduled for 19 July. On this basis, there was no reason to reject the evidence of the second defendant that he had administered the eye injections on 19 July 2006. A medical practitioner who keeps incomplete or inaccurate notes was not *ipso facto* negligent, if the notes or lack of them were

not a cause of the plaintiff's damage. Incomplete or inaccurate notes was not the *sine qua non* in a negligence action. Therefore, the absence of any reference to the eye injections in the operation record and the referral letter did not demolish the credibility of the second defendant on his assertion that the intravitreal eye injections were administered to the plaintiff on 19 July 2006. (paras 21 & 25)

(2) The second defendant was trained and qualified to administer intravitreal injections and perform vitrectomy. Thus, his decision to manage and treat the plaintiff himself could not be faulted. The second defendant did not undertake work that was beyond his competence and expertise. It could not be said that he did not behave as a reasonably prudent and diligent ophthalmologist in not referring the plaintiff to an ophthalmologist who specialised in vitreo-retinal work, and thereby committed a fault. There could be no reproach against him for exercising his professional judgment that he had the expertise to treat the plaintiff. (para 28)

(3) The delay of a day or two in the administration of the eye injections was justified in view of the plaintiff's poor health condition and the attendant risks involved when the eye was inflamed. The second defendant's decision to administer the eye injection under general anaesthesia at the stage when the plaintiff's condition had improved following systemic antibiotics and platelet transfusion was not only defensible but reasonable in the circumstances. The true test for establishing negligence in diagnosis or treatment on the part of a doctor was whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care. Therefore, the second defendant rendered treatment in a manner which was in conformity with the standard and recognised practice followed by the members of his profession. The delay in giving the eye injections had not been demonstrated to be unsafe or dangerous given the plaintiff's health condition at the material time. (paras 41 & 42)

(4) Early vitrectomy was not the first line of treatment in the management of endogenous endophthalmitis, and it was advisable for a doctor to wait for two to three weeks before performing the procedure under general anaesthesia, depending on the condition of the patient. Dr Pall Singh provided detailed explanations on his conclusions in which he arrived by not acting as an advocate for the second defendant. The second defendant's decision to defer vitrectomy could not be criticised as it was in accordance with the accepted protocol of treating endogenous endophthalmitis cases. The plaintiff had not established that the second defendant had departed from this standard approach. Thus, there was no breach on the part of the second defendant. (para 46)

(5) If the second defendant was found to have breached his duty to the plaintiff, the plaintiff must show that the breach of duty caused or materially contributed to her loss of vision in both her eyes. The courts would apply the "material contribution" test in circumstances where the precise cause of the plaintiff's injury or damage could not be proven. Anything which did not fall within the principle *de minimis non curat lex* would constitute a material contribution. The plaintiff's blindness was due to the klebsiella bacteria, and not due to the second defendant's negligence. She had contracted a potentially blinding disease that had a poor prognosis. According to PW5, the probability of a patient losing vision due to endogenous endophthalmitis is as high as 89% to 90%. Therefore, the plaintiff did not discharge her burden of proving that the negligence or breach of duty of the second defendant was the cause or contribution of her blindness. (paras 48 & 55)

(6) The plaintiff's left eye had perception of light at the time when she first went to Tung Shin Hospital and that hypotony developed only after the procedures carried out by PW5. There was a break in the chain of causation when the plaintiff subsequently lost her vision in the left eye in June 2007. Since there was no credible evidence adduced to suggest that PW5 was responsible for the plaintiff's blindness, the defence of *novus actus interveniens* was rejected. (paras 59 & 60)

Case(s) referred to:
Bolam v. Friern Management Committee [1957] 2 All ER 118 ***(refd)***
Chester v. Afshar [2004] 4 All ER 587 ***(refd)***
Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors & Other Appeals [1998] 1 CLJ 533 CA ***(refd)***
Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***
Payremalu Veerappan v. Dr Amarjeet Kaur & Ors [2001] 4 CLJ 380 HC ***(refd)***
Wu Siew Ying v. Gunung Tunggal Quarry & Construction Sdn Bhd & Anor [2011] 1 CLJ 409 FC ***(refd)***
Yeo Peng Hock Henry v. Pai Lily [2001] 4 SLR 571 ***(refd)***

Legislation referred to:
Evidence Act 1950, s. 114(g)

Other source(s) referred to:
Clerk & Lindsell on Torts, 17th edn, paras 2-24, 2-26

For the plaintiff - Manmohan S Dhillon (Khabir Dhillon with him); M/s P S Ranjan & Co
For the 2nd defendant - Johanan A Puthucheary (Nga Mei Yen with him); M/s Puthucheary

Reported by Sandra Gabriel

JUDGMENT

SM Komathy Suppiah JC:

Introduction

[1] This is an action for medical negligence by the plaintiff, aged 65 years against one Dr Ching Wing Seng, the second defendant, a consultant ophthalmologist who was the doctor who attended to and treated the plaintiff who was diagnosed with a condition described as endogenous klebsiella endophthalmitis. This infection is said to be caused by the klebsiella pneumonia bacteria, a virulent and aggressive organism which invades the victim's liver, blood and eyes. The plaintiff alleges that due to the inadequate treatment she received, she is now blind in both eyes. She holds the second defendant responsible for her loss of vision with due to his management in the care and treatment of her eyes between 16 July 2006 to 24 July 2006.

[2] In the midst of the trial, the plaintiff on 11 October 2013 discontinued the action against the first defendant, Consultant Physician Dr Lim Tye Ling, with no order as to costs, and recorded consent judgment with the third defendant Pantai Cheras Medical Centre Sdn Bhd. Pursuant to the terms of the consent judgment, the third defendant was to pay sum of RM15,000 gratis to the plaintiff on a without admission of liability basis.

Chronology Of Events

[3] The following is a summary of the chronology of events underlying the dispute:

(a) Since 12 July 2006, the plaintiff was experiencing fever and despite consuming medicine prescribed from a clinic, her temperature had not improved.

(b) On 15 July 2006, the plaintiff sought medical attention at Accident & Emergency Department of Pantai Cheras Medical Centre. After being attended to by the medical officer, the plaintiff was admitted into the ward under the care of the Consultant Physician Dr Lim Tye Ling. She complained of fever, nausea, body ache, backache, lethargy and flatulence for three days prior to admission. Her platelet count was found to be 65,000:

   (i) A provisional diagnosis of viral or bacterial infection possibly involving the urinary tract and liver (cholelithiasis); and

   (ii) The plaintiff was started on intravenous antibiotic to cover for the bacterial infection involving the urinary tract and the liver.

A (c) On 16 July 2006 at around 3.30pm during the ward round, the plaintiff complained to Dr Lim of some blurring of vision which she claimed she has had for two days but had omitted to mention earlier. The sclera of her eyes were noted to be inflamed bilaterally and the anterior chamber of both eyes looked "cloudy". Dr Lim
B contacted the second defendant and requested that he sees the plaintiff for further management of her eye complaint. The plaintiff's platelet count had, in the meantime drop dramatically to 43,000.

(d) On the same afternoon of 16 July 2006, the second defendant saw the plaintiff for the very first time at around 4.30pm:
C

(i) Examination of the eyes revealed conjunctival congestion with severe fibrin and hypopyon involving both eyes. Fundal views were not clear and both eyes had very poor vision;

D (ii) A diagnosis of bilateral anterior uveitis with severe fibrin and hypopyon was made; and

(iii) As the plaintiff was already on broad spectrum systemic antibiotics prescribed by Dr Lim, the second defendant added topical broad spectrum antibiotic Vigamox treatment for both the
E plaintiff's eyes.

(e) On 17 July 2006, Dr Lim instructed for MRI & MRA brain, chest x-ray, ultrasound abdomen to be done to look for other areas of sepsis:

F (i) The MRI brain and chest x-ray were normal. Ultrasound abdomen showed a multiloculated abscess in the right lobe of the liver. CT abdomen showed a single multiloculated abscess in the liver and thrombosis in the inferior vena cava.

G (f) Following the second defendant's review of the plaintiff's eye on 17 July 2006, he planned to give intravitreal injections of Amikacin and Vancomycin in the operation theatre as soon as possible when the general condition of the plaintiff permitted so.

(g) After reviewing the plaintiff again in the evening of 17 July 2006
H subsequent to the second defendant, Dr Lim changed the plaintiff's antibiotics to a triple antibiotic regime, ie intravenous Ceftriazone 2g two times daily, intravenous Amikacin 375mg two times daily and intravenous Flagyl 500mg three times daily.

I (h) During the review on 18 July 2006, the second defendant noted increased proptosis with congestion in the plaintiff's right eye and left eye still showing fibrin:

(i) The second defendant then instructed for a scan to be done of the orbits. In view of the plaintiff's systemic condition, the intravitreal injections were postponed. The second defendant also required the culture results on an urgent basis; and

(ii) The CT findings were suggestive of bilateral preorbital abscesses (right worse than left), focal scleritis at the optic nerve attachments sites bilaterally, and bilateral mild ethmoidal sinusitis.

(i) Dr Lim reviewed the plaintiff subsequent to the second defendant on 18 July 2006 morning, and conferred with the interventional radiologist Dr Beh Siu Joo regarding the drainage of the abscesses percutaneously under local anaesthesia:

(i) As Dr Beh was of the view that a percutaneous drainage would not drain the abscess adequately because of the multiloculated abscess, Dr Lim referred the plaintiff to the Consultant Surgeon Dr Meheshinder Singh;

(ii) Dr Lim had noted that the plaintiff's platelet count was a low 49,000; and

(iii) The urine culture test of 15 July 2006 returned with a report of klebsiella pneumonia on 18 July 2006.

(j) Following Dr Meheshinder's review of the plaintiff on 18 July 2006, the liver abscess was managed conservatively at that juncture in view of the clinical findings where the plaintiff was thrombocytopenic, and where she required correction of her lab parameters:

(i) Dr Meheshinder suggested and arranged for the transfusion of six units of platelet concentrate and two units of fresh frozen plasma, which was completed by the same evening of 18 July 2006.

(k) The consultant anaesthetist Dr Azian Syed Othman (PW3) had carried out a pre-operative assessment of the plaintiff on 18 July 2006.

(l) During Dr Lim's review of the plaintiff on 18 July 2006 evening after the transfusion, she had instructed for a blood test to be carried out the next morning.

(m) During the review on 19 July 2006 morning, the second defendant found that the plaintiff's right upper lid swelling had increased. Drainage of abscess was planned under general anaesthesia together with the administration of the intravitreal injections if the plaintiff was fit.

(n) The blood test of 19 July 2006 showed that the plaintiff's platelet had risen dramatically to 161,000.

(o) At around 11.15am on 19 July 2006, the plaintiff underwent an examination under general anaesthesia by the second defendant. There was severe inflammation in both orbits but no pus collection was found. There is a serious dispute between the parties as to whether intravitreal Vancomycin and Amikacin injections were given by the second defendant that day.

(p) A percutaneous drainage of the liver abscess was carried out later the same day by consultant radiologist Dr Beh Siu Joo. 40cc of thick pus was drained from the liver abscess.

(q) During a review on 20 July 2006 morning, the second defendant noted that the right upper lid swelling was better but the plaintiff's vision remained poor:

(i) A review in the afternoon showed the right eye cellulitis was subsiding and left eye anterior uveitis also subsiding.

(r) During the review on 21 July 2006 afternoon, the second defendant noted that the right eye swelling was getting localised and improving, the vision in the left eye was improving with better lights projection. A second CT scan was instructed to be done the next day.

(s) On 22 July 2006, the repeat MRI results revealed persistent right eye panophthalmitis and orbital cellulites, and left eye panophthalmitis. There was no localised abscess formation. Treatment was continued and a review was to be done on 24 July 2006.

(t) On 24 July 2006 however, the plaintiff discharged herself at her own risk (AOR) from the hospital, and did not return for follow up treatment.

(u) The plaintiff then sought treatment at Tung Shin Hospital where she was admitted for two weeks from 24 July 2006 until 7 August 2006:

(i) At Tung Shin Hospital, the plaintiff was under the care of one Dr Rita Yong Choy Lan, consultant opthalmologist (PW4), who performed a right lateral canthotomy and inferior cantholysis on the plaintiff and placed on systemic moxifloxacin; and

(ii) Dr Rita Yong (PW4) referred the plaintiff to Dr Seshan Lim, consultant eye surgeon (PW5) for further treatment. Phacoemulsification, pars plana vitrectomy and intraocular antibiotic injection for the left eye and drainage of pus from the right eye was administered by Dr Seshan Lim on 25 July 2006.

(v) During a review on 10 August 2006 by Dr Rita Yong (PW4), it was noted that the plaintiff's right eye had vague perception of light, and that the left eye had some localising perception of light.

(w) According to the report by Dr Seshan Lim (PW5) dated 5 September 2006, the plaintiff is permanently legally blind and unable to work.

(x) A subsequent report by Dr Seshan Lim (PW5) dated 21 July 2012 (exh. D5), said that the plaintiff's left eye which had improved to navigational vision of finger counting in the following three months from August 2006 had however started to deteriorate to light perception only in December 2006. The plaintiff was finally blind in her left eye in June 2007.

Witnesses

[4] The plaintiff gave evidence on her behalf. She also called the following witnesses:

(a) consultant ophthalmologist and vitreoretinal surgeon Dr Seshan Lim (PW1);

(b) consultant anaesthetist Dr Azlan Syed Othman (PW3);

(c) consultant ophthalmologist Dr Rita Yong (PW4); and

(d) the plaintiff's daughter Serena Siew (PW5).

[5] The second defendant gave evidence on his own behalf and called consultant ophthalmologist Dr Pall Singh (DW2), who has been practising as an ophthalmologist for the last 30 years as his expert witness.

Case For The Plaintiff

[6] It is the plaintiff's case that the second defendant's negligence and/or breach of duty of care caused or materially contributed her to be blind in both eyes. The allegations of negligence against the second defendant are particularised in para. 9 of the amended statement of claim as follows:

(a) failed to treat adequately and without delay the infection of the eyes;

(b) delayed in changing or reviewing the treatment when the plaintiff's eye condition showed no improvement; and

(c) failed to refer plaintiff to a vitreoretinal surgeon/another hospital with specialist and better facilities.

[7] In essence the plaintiff alleged that given her grave and serious condition, the second defendant intervened too late, and did too little to effectively treat or arrest the rare affliction of her eyes. It was alleged that the plaintiff's eyes could have been have saved if the second defendant had been more proactive and given intravitreal antibiotic injections to the eyes and performed a procedure called vitrectomy as soon as she was diagnosed with endogenous endophthalmitis.

Case For The Defendant

[8] The second defendant denied that he had been negligent and that the plaintiff's blindness was caused by his negligence.

[9] The second defendant contended that the plaintiff's condition was life threatening at the material time and the main priority was to save her life. Despite efforts by the second defendant to treat her eyes, the blindness was an unfortunate by-product of endogenous endophthalmitis which had already set in by the time he first examined her on 16 July 2006.

[10] The second defendant could not administer intravitreal Vancomycin and Amikacin under local or general anaesthesia before the 19 July 2006 because the of the presence of pus, inflammation and swelling around the plaintiff's eyes, and further, she had a low platelet count. He had to wait to ensure that her condition was stable, and it was only on 19 July 2006 that her general condition improved and he felt it was safe to give the injections.

[11] Alternatively, the second defendant also relied on the defence of *novus actus interveniens* based on the treatment given by Dr Seshan Lim to the plaintiff at Tung Shin Hospital.

Endogenous Klebsiella Endophthalmitis

[12] To better appreciate the plaintiff's affliction, it is necessary to give a short account of the endogenous endophthalmitis infection that the plaintiff contracted in this case. The medical evidence adduced at the trial disclosed the following salient facts. Endogenous endophthalmitis is an extremely rare and potentially blinding and fatal condition caused by the klebsiella bacteria. The bacteria is usually found in the gut, liver and lungs of humans, and is harmless unless it enters the bloodstream. However, when abscesses form in the liver, as what happened to the plaintiff, it then acts as a source for the klebsiella bacteria to enter the bloodstream and cause septicaemia. The plaintiff was diagnosed with septicaemia. Septicaemia takes place when the bacteria in the bloodstream produces toxins.

[13] Endogenous endophthalmitis is a intraocular infection resulting from the bacteria reaching the eye *via* the bloodstream. It is difficult to diagnose the endogenous klebsiella endophthalmitis given its low incidence. Blood culture is the most reliable way of establishing the diagnosis. It has a poor visual prognosis.

Issues

[14] Based on the submissions of the parties, the issues that arise for decision are as follows:

(i) Whether the second defendant administered the intravitreal injections during the procedure on 19 July 2006.

(ii) Whether the second defendant ought to have referred the plaintiff to a subspecialist, ie, vitreoretinal surgeon for treatment.

(iii) Whether the second defendant's management of the plaintiff was not in accordance with the accepted treatment of endogenous endophthalmitis.

(iv) Whether the second defendant's alleged failure as set out in (i) and (ii) had caused or materially contributed to the plaintiff's blindness in both eyes.

(v) Whether the alternative defence of *novus actus interveniens* applied in the circumstances of the case.

Whether The Second Defendant Administered The Intravitreal Injections

[15] It is not in dispute that after his second review of the plaintiff on 17 July 2006, the second defendant had planned for intravitreal eye injections to be administered to her as soon as possible in the operating theatre as part of the treatment plan for the eye infection. This is reflected in the medical record.

[16] The second defendant in his evidence said that he had administered the intravitreal eye injections during the examination of the plaintiff under anaesthesia procedure on 19 July 2006 although that was not mentioned in the operation record. According to him, the omission was because he was called away before he could complete the record and sign off. His evidence is consistent with and corroborated in a note made by one nurse Lau on the same day at 12.30pm which read, "Nothing written in POT to remind Dr Ching to fill up the post op treatment."

[17] There is a further document that merits examination in relation to this issue. This is the plaintiff's inpatient prescription form in which there is an entry that read, "Vancomycin injection and Amikacin on 19/7 at 11.20, confirmed SRN Zarina at 11.20 100mg." The entry made by

SRN Zarina indicated that the Vancomycin injection and Amikacin had been ordered in the ward. The time given here corresponded with the time of procedure stated in the swabs and instrument count sheet as "11.15 to 11.30".

[18] These further facts are also not in dispute. The second defendant obtained the consent of the plaintiff's daughter for eye injections on her mum on 17 and 18 July 2006. The nursing records indicated that on 18 July 2006 the second defendant cancelled his decision to give the eye injections. The operation record for 19 July 2006 did not show if eye injections were given. All that it indicated was that the second defendant had only undertaken examination of the eyes under general anaesthesia. Neither the nursing records nor the medical records make any mention of eye injections having been given. Apart from these documents, the second defendant made no mention of intravitreal injections as part of his treatment, in his referral letter which was prepared at the request of the plaintiff when she discharged herself and went to Tung Shin Hospital. In his referral letter, the doctor had only noted the details of the topical antibiotics administered to the plaintiff.

[19] Based on these undisputed facts, the plaintiff contended intravitreal injections were not given by the second defendant to treat the plaintiff's eye infections. It was argued that the contemporaneous evidence was inconsistent with the version of the second defendant. It was pointed out that note made by nurse Lau to the second defendant and the inpatient prescription form made by SRN Zarina were not properly proved by calling the nurses who had made these entries or by way of other evidence. In the absence of these witnesses, there is no evidence that the Vancomycin injection and Amikacin ordered by Zarina was delivered to the operating theatre when the second defendant performed the eye examination under anaesthesia and were, in fact administered into the plaintiff's eye through the intravitreal route. The failure to call nurse Lau and Zarina, it was strongly argued, called for the invocation of s. 114(g) of the Evidence Act 1950.

[20] On the other hand, the second defendant maintained that the failure to minute in the operation record that the intravitreal eye injections were given was not *ipso facto* conclusive proof that they were not given. It was contended that the entries made by Lau and Zarina provided crucial support to the second defendant's assertion that the injections were given.

[21] Having considered all the evidence on this issue, I am inclined to accept the testimony of the second defendant that the intravitreal eye injections were administered by him on the 19 July 2006 at about 11.30 in the morning. His evidence is amply corroborated by the entries in the records made by Lau and Zarina. Although the nurses who made

the entries in these two documents were not called, but the omission to call them is not fatal. In this context, it is significant to bear in mind that there is unchallenged evidence that on the 18 and 19 July 2006, the second defendant had arranged for the plaintiff to be given eye injections, but the injections scheduled for the 18 July were cancelled, and that cancellation is recorded. However, there is no record of any cancellation of the injections scheduled for the 19 July. On this basis, there is no reason to reject the evidence of the second defendant on the question of whether he had administered the eye injections on 19 July 2006.

[22] There are two further points to be made. The first is based on a contradiction between the evidence of the second defendant and Dr Azian. In his evidence, the second defendant explained that the reason why the eye injections could not be given sooner was because he was advised on 17 July 2006 by the anaesthetist that the plaintiff was not fit for general anaesthesia. The plaintiff contended that the second defendant had lied about having consulted an anaesthetist on 17 July 2006 and, in this connection relied on Dr Azian's evidence that neither she nor her anaesthetist colleagues were consulted by the second defendant before 18 July 2006.

[23] Dr Azian's evidence warrants examination with discernment. She accepted that she was the anaesthetist who had assisted the second defendant to assess if the plaintiff was fit for general anaesthesia on 19 July 2006. According to her, however, she could not recall whether the intravitreal eye injections were administered on 19 July 2006 and, would rely on the operation record to conclude that it was not administered. Under cross-examination, she accepted that she had not minuted in her own records that she had assessed the condition of the plaintiff on 19 July 2006. She further accepted that neither in her medical report dated 29 May 2012, had she mentioned that she had assessed the condition of the plaintiff on the said date.

[24] The admissions of Dr Azian in this connection, demonstrates that her evidence that neither she nor her anaesthetist colleagues were consulted before 18 July 2006 is not reliable. It is reasonably probable that this was not recorded. It cannot be gainsaid that memory fades and recollections change over periods of time. It must be accepted that individuals who repeatedly engage in certain activities will be hard-pressed to recall an otherwise unexceptional encounter.

[25] The second point has to do with the incomplete records kept by the second defendant. It was suggested that this was indication that he was negligent. In my view, a medical practitioner who keeps incomplete or inaccurate notes, is not *ipso facto* negligent, if the notes or lack of them are not a cause of the plaintiff's damage. Incomplete or inaccurate

notes is not the *sine qua non* in a negligence action. I therefore do not consider that the absence of any reference to the eye injections in the operation record and the referral letter demolishes the credibility of the second defendant on his assertion that the intravitreal eye injections were administered to the plaintiff on 19 July 2006.

Whether The Second Defendant Ought To Have Referred The Plaintiff To A Subspecialist

[26] It is common ground that the second defendant owed a duty and standard of care to the plaintiff as the opthalmologist who treated her. It is incumbent on the plaintiff to prove that the second defendant had breached this duty in not advising the plaintiff that there were opthalmologists who specialised in vitreoretinal surgery. An examination of the evidence led on this issue revealed that in the year 2006, there was no established subspeciality of vitreoretinal surgery in Malaysia. It was merely by peer recognition. This fact was accepted by Dr Seshan Lim, is a vitreoretinal surgeon. All general opthalmologists in 2006, were trained and qualified to administer intravitreal injections and perform vitrectomy.

[27] The second defendant candidly accepted that he did not advise the plaintiff that there were opthalmologists who sub-specialised in vitreoretinal surgery, outside Pantai Medical Centre, whom she could consult. According to him, he proceeded to treat the plaintiff for endogenous endophthalmitis as he was trained and qualified to administer intravitreal injections and perform vitrectomy.

[28] The plaintiff contended that failure to provide advice was actionable on the ground that the patient had a right to self-determination regarding her treatment. In support of this proposition, he cited the case of *Chester v. Afshar* [2004] 4 All ER 587 and *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229; [2007] 1 MLJ 593. I accept that the proposition of law that where a doctor is wanting in the requisite speciality and is unable to treat the patient, he will be under a duty either to seek advice from an appropriate specialist or to refer the patient to another specialist. If he attempts to diagnose or treat the patient himself he is, in effect, undertaking work beyond his competence, and will be liable if harm results. However, I find myself unable to agree with the plaintiff's submission that because of the serious nature of her eye condition, the second defendant should have referred her to an ophthalmologist who specialised in vitreoretinal work, instead of attempting to treat her himself. It cannot be gainsaid that endogenous endophthalmitis is a potentially blinding disease. In light of the evidence that in 2006 there was no established subspeciality of vitreoretinal and the second defendant was trained and qualified to administer intravitreal injections and perform vitrectomy, his decision to manage and treat the

plaintiff himself cannot be faulted. In my view, he did not undertake work that was beyond his competence and expertise. It cannot thus be said that he did not behave as a reasonably prudent and diligent ophthalmologist in not referring the plaintiff to an ophthalmologist who specialised in vitreoretinal work, and thereby committed a fault. There can be no reproach against him for exercising his professional judgement that he had the expertise to treat the plaintiff. I therefore reject this complaint.

Accepted Treatment Of Endogenous Endophthalmitis

[29] The question of whether the second defendant has failed to meet the standard of care that he owed the plaintiff in the treatment he gave her, is the central issue in this case. The plaintiff bears the burden of proving, on a balance of probabilities, that the second defendant breached the requisite standard of care. If the plaintiff proves that he did, then this court may hold the second defendant liable for her blindness.

[30] It was accepted by both parties that the test that is applicable in medical negligence cases is that formulated by McNair J in *Bolam v. Friern Management Committee* [1957] 2 All ER 118. It is encapsulated in the oft-quoted passage at p. 121:

> Where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

McNair J, continued at p. 122:

> A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. ... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

[31] The Malaysian Court of Appeal echoed the same view in *Dr Chin Yoon Hiap v. Ng Eu Khoon & Ors & Other Appeals* [1998] 1 CLJ 533; [1998] 1 MLJ 57. It was held as follows:

> The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill acting with ordinary care would be guilty of.

[32] In order to answer the question of whether the second defendant met the standard, it is therefore necessary to determine what was the accepted practice of ophthalmologists at the material time in the treatment of endogenous endophthalmitis. It is common ground that the plaintiff's eyes had been already infected by endogenous endophthalmitis before she went to Pantai Cheras Medical Centre Hospital, and was examined by the second defendant.

Expert Evidence

[33] The plaintiff did not call any expert witness, but relied on the evidence of Dr Sheshan Lim and Dr Rita Yong, whilst the second defendant relied on the evidence of his expert witness, Dr Pall Singh to establish the common accepted practice in the treatment of endogenous endophthalmitis. Dr Pall Singh has been a senior consultant ophthalmologist at Tun Hussein Onn National Eye Hospital since September 1990. The purpose of expert testimony is to provide the evidence upon which the court decides whether there has been negligence or not and it is imperative that experts should be independent and not be advocates for one side or the other. In the end, it is not the experts but this court that decides the various issues before it. Otherwise, the experts and not the court would be deciding. The court may accept or reject in whole or in part the evidence of an expert witness. Fortunately, in the present case, there is no divergence of opinion between the medical evidence led by the plaintiff and the second defendant. They agreed on several crucial issues. They agreed that the mainstay in the management of endogenous endophthalmitis is prompt and aggressive treatment with systemic intravenous antibiotics and intravitreal antibiotics. They also agreed that vitrectomy has a role in the treatment of endogenous endophthalmitis. There was, however, a difference of opinion as to whether vitrectomy should be performed at an early stage of the treatment or should be performed after a week or two after the patient has been put on systemic intravenous antibiotics.

[34] In his report, Dr Pall Singh addressed the treatment given for endogenous endophthalmitis by opthalmologists in Malaysia at p. 6:

> Management
>
> Medical
>
> Systemis Therapy - Prompt institution of intensive intravenous antibiotics is critical endogenous endophthalmitis. This not only treats the remote focus of injection and sepsis, but also the ocular disease. Prolonged intravenous therapy is usually required for 2 to 4 weeks, until it is certain that the systemic infection has been eradicated.

Before culture results are known, initial therapy should be with broad-spectrum antibiotics at the highest recommended dosage. For Gram-positive cover, intravenous vancomycin is warranted in view of the potential severity of the disease and consequences. Good Gram-negative coverage is provided by third-generation cephalosporins, ciprofloxacin and aminoglycosides. Although intravenous antibiotics can reach therapeutics concentrations in affected eyes, the use of systemic antibiotics that have good intraocular penetrations and bioavailability is preferred.

Subsequent therapy can be tailored according to sensivity results and response to treatment.

Intravitreal Therapy - Although the value of intravitreal antibiotics over and above the use of intravenous antibiotics has not been definitely established, most cases are of posterior diffuse disease and panophthalmitis which denote severe infection with extension of organisms into the vitreous. These cases should be treated as aggressively as possible with both systemic and intravitreal antibiotics.

Topical antibiotics are definitely indicated if keratitis develops and adjunctive therapy includes the use of cycloplegics, ocular hypotensives and topical steroids.

The use of intravitreal and systemic steroids in the management of endopthalmitis remains controversial, with systemic steroids being contraindicated in patients with inadequately controlled sepsis. Intravitreal steroids are usually avoided in the early management of endogenous endopthalmitis, especially in the presence of large choroidal abscesses in which the infection may not be adequately and rapidly controlled by intravenous antibiotics.

Surgical - The timing of and necessity for virectomy remains unclear in endogenous as compared with post-operative endopthalmitis. Vitrectomy can remove opacities, debris and microorganisms in the vitreous with good efficacy, simultaneously allowing irrigation of the vitreous cavity with antibiotics and treatment of complications such as retinal detachment. Several important factors arise when considering surgery.

Vitrectomy will be more useful in posterior diffuse disease and be considered especially if such cases appear to be progressing despite adequate medical therapy. In cases of fungal endopthalmitis, vitrectomy provides a good specimen for microbiology and effectively reduces the number of organism. It is also crucial to consider the overall status of these individuals, many of whom will be desperately ill from systemic sepsis. In some cases, these patients may pose too great an anaesthetic risk for surgery. In others, the patient may be moribund and near death.

A **Intravitreal Injections**

[35] In her medical report dated 29 June 2012, Dr Rita Yong quoted the following extract from a medical publication:

> Intravitreal antibiotics injection have revolutionised treatment of
B exogenous endophthalmitis but their usefulness in endogenous cases is controversial. Similarly surgical intervention (i.e. vitrectomy) is widely accepted in postsurgical/traumatic endophthalmitis but its benefits in Endogenous Endophthalmitis have been debated. ... The outcome of posteruir diffuse endophthalmitis or panophthalmitis is frequently blindness regardless of treatment measures.
C

[36] Dr Pall Singh in his evidence explained that there is no established protocol regarding the administration of intravitreal antibiotics for endogenous endophthalmitis. Accordingly to him, "it does not mean that there is negligence if it is not given, and that if given it is the correct
D thing."

[37] He pointed out that in endogenous endophthalmitis, the source of infection comes from the blood vessels and affects the whole eyeball itself, and the blood retinal barrier is broken. Treating the whole eyeball at this point is more critical than just getting antibiotics into the eye.
E Giving injections directly into the eye without systemic antibiotics when the whole eye is inflamed is not relevant. The following extract of his evidence, in this connection, merits reproduction:

At p. 429:

F
> Now I am talking about endogenous. That is coming from the blood system which has come through the blood vessels and it is affecting the whole eyeball itself, the blood vessels. After that, from the blood vessels, it goes into here. So that source of infection is different, it has come from the blood vessels and the blood vessels which have the
G blood retinal barrier is broken. And that is why the infection goes into the eyeball. So it is continuously ... infection is coming from some other source, bacteria septic emboli come, they lodge in the blood vessels and all the walls are also inflamed. So that is a different disease entity in a way compared to the exogenous infection. So we have to bear that in mind when we are talking of treatment. A lot of the
H guidelines given are all for exogenous infection. It is not for endogenous. I think that is very important if you could understand that part of it.

At p. 436:

I
> To me, treating the whole eyeball is more important than just getting antibiotics into that place. And it is not a simple procedure as pointed out earlier. But I think when the eye is inflamed, swelling, chemosis, I will be reluctant to put an injection straightaway like that. I'll prefer for that thing to settle and then, if necessary, do it at the appropriate

> time. And that literature tells you that the role of that injections are still controversial. So when you consider a procedure, I think you have to bear in mind the risks and the benefit. And in a tensed eyeball with chemosis, infection around, I think I will be also reluctant to do straightaway.

He further said (at 488):

> Yes, when you have endogenous infection, what is the treatment? The treatment is treating the whole body, antibiotics going into the system, coming into the eye, antibiotics treating that. You cannot say that the systemic treatment is different from eye treatment. The eye treatment here is giving intravenous injection of antibiotics, enough dose and strength so that the antibiotics travel into the eye. There is hardly any role of giving injections directly into the eye when the whole eye is inflamed.

At p. 489:

> What would have been the role of Intravitreal with systemic, would it had been minimal?
>
> Yes, because a lot of people give Intravitreal injections for exogenous, that is why some of them said, oh, well might as well give inside. But before you give inside, you really have to look at the various issues involved. And if you just give injections here without systemic, I think there is no role. So role is very, very minimal to me it is not negligent if you don't give.

At pp. 434-435:

> Panophthalmitis means all the layers are involved. 'Pan' means it is not only the retina or the choroid, it is infection of all the layers and abscess is outside. Abscess around the eyeball which are noted in the scan because you have other tissues around here. So all that are also having infection. Which means you have to treat all that infection rather than just the Intravitreal injections. Intravitreal injection, there is a controversy whether it is useful or not ...

[38] The second defendant in his evidence explained that the reason the intravitreal antibiotics injection was not given sooner was because the plaintiff had pus, abscess, inflammation, swelling and chemosis in her eyes and, in his judgement, it would be risky to do so. Intravitreal injections can cause retinal haemorrhage, retinal detachment, introduce infection into the eye. In addition, he explained that the plaintiff was acutely ill as she had septicaemia, thrombocytopenia and inferior vena cava thrombosis, and her platelet count was low which made her unfit for surgical intervention.

[39] Dr Pall Singh expressed the view that the decision of the second defendant to defer the injections cannot be faulted. According to him, given the health condition of the plaintiff at the material time, it would have been dangerous to inject, and that he too would have waited for the plaintiff's condition to settle to avoid any risks. The risks involved was articulated by Dr Pall Singh as follows:

> It is an injection at this particular site, you cannot go too far, there is a small window which is safe to inject. If it injects in front, you hit the lens, if you inject behind, you hit the retina. So it is a very small pars plana area of about 3mm to 4mm. And that introduces antibiotics directly into the eyeball, but you have these tissues here. And in the presence of pus, abscess around, I think it is dangerous to inject. Intravitreal injections have become very simple now compared to 10-20 years ago.

[40] On the question for the need for the intravitreal injections to be administered under general anaesthesia, Dr Pall Singh explained that when the eye is inflamed, swollen and infected, it is preferable to administer the injections under general anaesthesia. His observations merit reproduction at some length:

> When it's inflamed, we call it a hot eye, that means the one with infection around, firstly, it is not easy to give and secondly the tissues are inflamed, there is infection around. So putting a needle into it is not easy and you can introduce infection, you can also hit on the lens and cause more damage as pointed out in some of the earlier articles compared to a quiet eye. In a quiet eye, when you give injections, it is much, much safer, when it stands, chemosis, you are supposed to give in that small area, pars plana, you are supposed to measure that, it's only 3.5mm from here. And when the eye is swollen, how are you going to measure that, the measurements are not there. And therefore the risk of giving injections in those situations is higher. That's why many of us are reluctant to give injections straightaway. And this is one reason why general anesthesia may be preferred because you want to try to give it in the exact spot.

[41] The question that I need to address is whether the decision of the second defendant to administer the eye injections only on the 19 July 2006 was contrary to the accepted practice in the treatment of endogenous endophthalmitis. Based on the evidence of Dr Pall Singh, which I accept, the delay of a day or two in the administration of the eye injections was justified in view of the poor health condition of the plaintiff and the attendant risks involved when the eye is inflamed. The second defendant's decision to administer the eye injection under general anaesthesia at the stage when the plaintiff's condition had improved following systemic antibiotics and platelet transfusion is not only defensible but reasonable in the circumstances. In the realm of diagnosis and treatment there is ample scope for genuine differences of opinion,

and one man is clearly not negligent merely because he decided to be cautious and wait to ensure that it was safe to give the injections. In my view, the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care. This, the plaintiff has not done.

[42] I therefore conclude that the second defendant rendered treatment in a manner which was in conformity with the standard and recognised practice followed by the members of his profession. The delay in giving the eye injections has not been demonstrated to be unsafe or dangerous given the plaintiff's health condition at the material time.

Vitrectomy

[43] Insofar as the role of vitrectomy is concerned with regard endogenous endophthalmitis, it is common ground that there are currently no clear guidelines on the management of this condition, and that its exact role is still undefined. The medical evidence established that another factor to weigh against early surgery is that many victims of endogenous endophthalmitis are acutely ill when it develops, and until overall stabilisation has been achieve they represent poor candidates for general anaesthesia. Avoiding a trip to the operating room during this initial period is perhaps more prudent.

[44] According to Dr Pall Singh, vitrectomy is not the first line of treatment in the management of endogenous endophthalmitis. It is only considered after the stabilisation of the condition and that he would not consider vitrectomy in the first one week of endogenous endophthalmitis treatment, or even two to three weeks, depending on the condition of the patient as antibiotics must be given for at least two to four weeks.

[45] The role of early vitrectomy in endogenous endophthalmitis, the second defendant said, does not cure the infection. He expressed the following opinion:

> ... if you understand Endogenous Endophthalmitis, it is just like a room, when the room is full of smoke and the smoke is all coming out from the outside, if you only remove the smoke in the room, it doesn't settle the issue. Outside the room, the smoke will still keep coming in. So in Endogenous Endopthalmitis, infection is all coming from outside. It's from the bloodstream, it passes through the orbit, it passes through the ... and then it passes into the retina. So retina is the most inner thing. If we do Vitrectomy, Vitrectomy is you go inside the eye removing the jelly within the retina and it doesn't solve all the issue. You're not touching the choroid, you're not touching the wall of the eye and all of that part are still infected and if you only remove a single bit of things inside the eye, you are not curing the issue, the issue is infection are coming from the outside.

[46] I accept the evidence of Dr Pall Singh that early vitrectomy is not the first line of treatment in the management of endogenous endophthalmitis, and it is advisable for a doctor to wait for two to three weeks before performing the procedure under general anaesthesia, depending on the condition of the patient. It is amply supported by medical publications on the treatment of endogenous endophthalmitis. Dr Pall Singh provided this court with detailed explanations on why he came to his various conclusions. The way in which he arrived at his conclusions indicate to this court that he was not acting as an advocate for the second defendant. On the evidence, I am satisfied that the decision of the second defendant to defer vitrectomy cannot be criticised as it was in accordance with the accepted protocol of treating endogenous endophthalmitis cases. The plaintiff has not established that the second defendant had departed from this standard approach, and thus there is no breach on the part of the second defendant.

[47] In view of my findings, that the second defendant had not breached his duty of care he owed to the plaintiff as an ophthalmologist, it is strictly unnecessary to consider or explore the remaining issues in this case. However, in the event, I am wrong in my findings, I would state my views on the other issues.

Causation

[48] The next question to be considered is, if contrary to my findings, the second defendant is found to have breached his duty to the plaintiff, whether the plaintiff has shown that the breach of duty caused or materially contributed to her loss of vision in both her eyes. The cases on this subject have established that courts will apply the "material contribution" test in circumstances where the precise cause of the plaintiff's injury or damage cannot be proven, as in this case. Anything which did not fall within the principle *de minimis non curat lex* would constitute a material contribution. See *Wu Siew Ying v. Gunung Tunggal Quarry & Construction Sdn Bhd & Anor* [2011] 1 CLJ 409; [2011] 2 MLJ.

[49] How does the plaintiff prove causation? The cases on the subject have established that causation need not be determined by scientific precision. In most cases, and certainly in this case, this court does not have the expertise to determine causation without the help of experts. However, it is still this court that must determine causation. Expert medical evidence is very helpful in medical negligence cases in determining causation, although it is not conclusive. That standard is the balance of probabilities. The plaintiff will not have met this standard by showing that there is a possibility of some causal connection.

[50] The parties in this case provided this court with competing theories for her blindness. The plaintiff contended that her vision could have been saved if intravitreal injections and vitrectomy had been considered by the second defendant in the early stage of the treatment. In support of this position, she relied on the evidence of Seshan Lim and Dr Rita Yong. Dr Pall Singh opined that the complications suffered by the plaintiff were due to the aggressive nature of klebsiella pneumonia endogenous endophthalmitis from liver abscess and not caused by the acts or omission of the second defendant.

[51] The second defendant relied heavily on the following passage in the Singapore case of *Yeo Peng Hock Henry v. Pai Lily* [2001] 4 SLR 571 to support his position that it was not his negligence that caused the plaintiff's blindness. This was also a case involving klebsiella bacteria where the patient lost the vision of her left eye despite intravitreal injections and vitrectomy performed in the early stages of the treatment. In that case, the plaintiff sued the defendant, a general practitioner for medical negligence for failing to advise her to see an eye specialist on her complaint of blurry vision. She saw a specialist only the next day, because of the failure of the defendant to warn her that it was potentially serious. The Court of Appeal held (at p. 585):

> Turning to the treatment of EKE, Dr Ang opined that, even if an aggressive therapeutic approach is adopted, there is no clear evidence from his experience and in medical literature to suggest that such measures will improve the outcome. He added that the prognosis of EKE is poor, and that the chances of treatment were poor. Klebsiella bacteria are particularly virulent organisms, and can destroy the eye very rapidly, sometimes within 24 hours. Even with appropriate treatment, endophthalmitis can occur.

It was said at 589:

> The burden of proof rests squarely on Ms Pai, and in our judgment, on the basis of the evidence given by Prof Cartwright and Dr Ang, Ms Pai had not discharged the burden of proving, on a balance of probabilities, that had Dr Yeo advised her to go to the SGH or SNEC immediately on the afternoon of 23 December 1996 and had she gone there that afternoon, her left eye would have been saved. She had therefore not proven that Dr Yeo's negligence and/or breach of duty caused or materially contributed to the loss of her vision in the left eye. On this ground, her claim cannot succeed.

[52] No expert witness was called by the plaintiff despite the fact that on 23 July 2013, the plaintiff's solicitors had informed the court that they have appointed one Dr JS Wong of International Specialist Eye Centre Malaysia, Mid Valley City as their expert. It is submitted that an adverse inference should be drawn against the plaintiff under s. 114(g) of the Evidence Act 1950 in view of the absence of the opinion and the witness himself for purposes of the trial.

[53] It was strongly argued that the absence of an independent expert witness on the part of the plaintiff should not be disregarded and referred to the following *dictum* of VT Singham JC (as he then was) in the case of *Payremalu Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380 at p. 381; [2001] 3 MLJ 725 (at p. 726):

> It was important for the plaintiff to have adduced medical or expert evidence to support the allegations contained in the statement of claim against the defendants ... . The testimony of a medical expert would have been most material to the issue of causation but, unfortunately, the plaintiff had opted not to call such evidence. Counsel for the plaintiff had been misconceived in submitting that expert witness need not be called to prove medical negligence.

[54] On the failure of the plaintiff to call an expert witness, in my judgment, this does not call for the invocation of s. 114(g) of the Evidence Act. The court was informed that the expert witness that the plaintiff had intended to call, had changed his mind about giving evidence in this case. In the circumstance, there is no justification for drawing and adverse inference against the plaintiff.

[55] I turn to examine the issue of causation. Why did the plaintiff go blind in June 2006? What caused her blindness and was the second defendant's in action or delay a contributing factor? I accept Dr Pall Singh's analysis of the cause of the plaintiff's blindness that it was due to the klebsiella bacteria, and not due to the second defendant's negligence. She had contracted a potentially blinding disease that had a poor prognosis. According to Dr Sheshan Lim the probability of a patient losing vision due to endogenous endophthalmitis is as high as 89% to 90%. In fact, in one of the medical articles quoted by Dr Rita Yong in her medical report, the author opined that, "the outcome of posterior diffuse endopthalmitis or panophthalmitis is frequently blindness regardless of treatment measures." On the basis of these evidence, I find that the plaintiff has not discharged her burden of proving that the negligence and/or breach of duty of the second defendant was the cause or contribution of her blindness.

[56] I therefore would have dismissed the plaintiff's claim on this ground as well.

Novus Actus Interveniens

[57] As earlier mentioned, the second defendant also relied on the defence of *novus actus interveniens* in the alternative since the plaintiff sought and received treatment at Tung Shin Hospital after her self-discharge from Pantai Cheras Medical Centre on 24 July 2006.

[58] Reference was made to *Clerk & Lindsell on Torts*, 17th edn. at paras 2-24, 2-26 on the concept of *novus actus interveniens*:

> This concept of *novus actus interveniens* acts in this manner: If a particular consequence of the defendant's wrongdoing is attributable to some independent act or event which supersedes the effect of the initial tortuous conduct, then the defendant's responsibilities may not extend to the consequences of the supervening event. In short, if there is a break in the chain of causation then the original wrong doer is not liable for starting the wrong.

[59] It was stressed by the second defendant that the plaintiff's left eye had perception of light at the time when she first went to Tung Shin Hospital on 24 July 2006, and that hypotony developed only after the procedures carried out by Dr Seshan Lim. As the plaintiff subsequently lost her vision in the left eye in June 2007, it was submitted that there was a break in the chain of causation.

[60] There was no credible evidence adduced to suggest that Dr Seshan Lim was responsible for the plaintiff's blindness. I therefore would have rejected this defence.

Conclusion

[61] I therefore dismiss the plaintiff's claim with costs of RM20,000.